

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08092

# CERTIFICATE OF DEATH

08079

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. LENGTH OF STAY IN 15 <b>15 YEARS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON, R.F.D. 5</b>		d. STREET ADDRESS <b>17-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>J.</b> Last <b>ANDERSON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>1</b> Year <b>19 67</b>	
5. SEX <b>FE MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/17/82</b>
9. AGE (In years lost birthday) yrs. <b>84</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b> Hours <b>1</b> Min. <b>6</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRESSMAKER</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>	
14. FATHER'S NAME <b>JOHN T. MOORE</b>		15. MOTHER'S MAIDEN NAME <b>HENRIETTA SHAW</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>212-30-3961</b>	
18. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bil. pulmonary embolism</b> DUE TO (b) <b>Thrombosis of right leg veins</b> DUE TO (c) <b>1466X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/3</b> , 19 <b>51</b> , to <b>6/1</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>6/1</b> 19 <b>67</b> , and that death occurred at <b>9 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Pete W. Rieckert</b>		22b. DATE SIGNED <b>6/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Pete W. Rieckert</b>		22d. ADDRESS <b>E.S.S.H., CAMBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>JUNE 4, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Meth. Com. Cherry Hill Cecil, Md.</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Ralph Hicks</b>		25a. REC'D BY REGISTRAR <b>Charles Jones</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>		DATE <b>JUN 5 1967</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
08093 08080											
1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u> c. LENGTH OF STAY IN <u>5 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CAMBRIDGE - Md. Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>DORCHESTER</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u> <u>09-1</u> d. STREET ADDRESS <u>806 CENTER</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ROSINA</u>			First Middle Last			4. DATE OF DEATH <u>BARKON</u> <u>6</u> <u>3</u> <u>1967</u>			Month Day Year		
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-28-1915</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>So. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WASHINGTON MCKNIGHT</u>						14. MOTHER'S MAIDEN NAME <u>ELIZABETH ROSE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>MONKOE SMITH</u>		Address <u>806 CENTER</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia and Cardiac failure</u> <u>443X</u> DUE TO (b) <u>Hypertensive C.V.D.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>3 weeks</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>											
MEDICAL CERTIFICATION											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-6-67</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)											
ACTUAL SIGNATURE <u>[Signature]</u>		EXAMINER'S NAME (Type) <u>[Signature]</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/6/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WAUGH CHAPEL</u>				22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE MD</u>			
23. FUNERAL DIRECTOR <u>Alida L. West</u>				ADDRESS <u>Baltimore Md</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
				DATE <u>JUN 8 1967</u>							

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "MURDER" and "SMITH" are faintly visible.]*

FOR STATE  
HEALTH DEPT.

08094

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08081

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>O.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STEVENSVILLE</b>	
c. LENGTH OF STAY IN 1b <b>18 MONTHS</b>		17-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>RICHARD TILDEN BAXTER</b>		4. DATE OF DEATH Month Day Year <b>JUNE 27 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/22/75</b>
9. AGE (In years last birthday) yrs. <b>91</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>RICHARD BAXTER</b>		14. MOTHER'S MAIDEN NAME <b>WILHEMENA CARMINE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL PNEUMONIA</b> 9047 DUE TO <b>FRACTURE NECK L. FEMUR</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>5 MO.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FELL IN HOSPITAL</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>L-2-67</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOSPITAL</b>	20f. (City or town) (County) (State) <b>CAMBRIDGE DOR. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) <b>JOHN MACE JR.</b>		22. DATE SIGNED <b>6/27/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>JUNE 30</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>STEVENSVILLE</b>		23d. LOCATION (City or Town) (County) (State) <b>STEVENSVILLE MARYLAND</b>	
24. FUNERAL DIRECTOR <i>Edgar L. Lane Church Hill Md</i>		25a. REC'D BY REGISTRAR DATE <b>JUN 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08095 CERTIFICATE OF DEATH 08082									
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital</b>					d. STREET ADDRESS <b>RFD # 3</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>THOMAS</b> Last <b>BENNETT</b>					4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>19 67</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 18, 1893</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shirt Factory</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Levi Thomas</b>					14. MOTHER'S MAIDEN NAME <b>Anna Marshall</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-9796</b>		17. INFORMANT Address <b>Mr. Harry Bennett, RFD#3, Cambridge, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforated Duodenal ulcer &amp; peritonitis</b> <b>H201</b> DUE TO <b>Coronary Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>?</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>6/12/67</b> , 19 <b>67</b> , to <b>6/16/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/16/67</b> , 19 <b>67</b> , and that death occurred at <b>11:15</b> A.M. from the causes and on the date stated above. 22a. SIGNATURE <b>Lawrence Maryanov</b> 22c. PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b> 22d. ADDRESS <b>610 Race St. - Cambridge, Md</b> 22b. DATE SIGNED <b>6/16/67</b> 22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>June 19, 1967</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Dail Family Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>RFD #3, Cambridge, Md.</b> 24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b> 25a. REC'D BY REGISTRAR <b>JUN 21 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08096

08083

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>O.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>7 WEEKS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTER</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		d. STREET ADDRESS <b>17</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA ELIZABETH BENTON</b>		4. DATE OF DEATH Month Day Year <b>JUNE 20 1967</b>	
5. SEX <b>FE MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/30/92</b>
9. AGE (In years last birthday) yrs. <b>75</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>xx</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JAMES H. BENTON</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELIZABETH -</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-16-9923A</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bonechopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. - Diabetes Mellitus - Chronic myocarditis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/1</b> , 19 <b>67</b> , to <b>6/20</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/20</b> 19 <b>67</b> , and that death occurred at <b>6/20</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Efrain C. Fernandez</b>		22b. DATE SIGNED <b>6/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Efrain C. Fernandez</b>		22d. ADDRESS <b>E.S.S. HOSPITAL, CAMBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>JUNE 22</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>KINGSLEY CHURCH YARD</b>		23d. LOCATION (City or Town) (County) (State) <b>CHESTER MD.</b>	
24. FUNERAL DIRECTOR <b>Edgar L. Lane Church Hill Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 20 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08097

CERTIFICATE OF DEATH

08084

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		d. STREET ADDRESS <b>501 Radiance Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FLORENCE BROWN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1882</b>
9. AGE (In years lost birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. Ben Brown</b>		14. MOTHER'S MAIDEN NAME <b>Laura M. ( ? )</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>Miss Mabel Wright, Cambridge, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal Hemorrhage</b> DUE TO (b) <b>Rupture of Esophageal Varices</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Heart Disease with Cardiomegaly.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4-2-56</b> , 19__, to <b>6-27-67</b> , 19__, that (I) (we) lost saw the deceased alive on <b>6-27-67</b> , 19__, and that death occurred at <b>1:15 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Albert E. Bunker</b> M.D.		22b. DATE SIGNED <b>6-29-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALBERT E. BUNKER, M. D.</b>		22d. ADDRESS <b>200 Md.Ave., Cambridge, Maryland 21613</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 29 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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UNITED STATES OF AMERICA

DEPARTMENT OF COMMERCE

Secretary

Director

Assistant Secretary

Office of the Director

Office of the Assistant Secretary

Office of the Assistant Secretary

Office of the Assistant Secretary

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08085

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE MD</b>		c. LENGTH OF STAY IN 1b <b>17.2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glasgow Nursing Home</b>		d. STREET ADDRESS <b>312 GLENBURN LANE</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELLEN</b> Last <b>CAHALL</b>		4. DATE OF DEATH Month <b>6</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-23-1892</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min. <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Cahall</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Chiffins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Louise Hughes Claymont, Delaware</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>6-29, 1967</b> , to <b>6-29, 1967</b> , that (1) (we) last saw the deceased alive on <b>6-29, 1967</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James F. McCarter</b>		22b. DATE SIGNED <b>6-29-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES F. MCCARTER</b>		22d. ADDRESS <b>Box 386 CAMBRIDGE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-2-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>	23d. LOCATION (City, town or county) (State) <b>Greensboro, Maryland</b>
24. FUNERAL DIRECTOR <b>J. E. Borealis, Translators, Md</b>		25a. REC'D BY REGISTRAR <b>JUL 5 1967</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

1400

Housekeeper	None	Maryland	USA
Charles Cahill		Catherine O'Connell	
No	Unknown	Louise Hughes Clayson, Delaware	

Greenaborn, Mary Ann      Greenaborn      7-2-02      Burial



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08093

## CERTIFICATE OF DEATH

08087

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>			c. LENGTH OF STAY IN 1b <b>RURAL - CAMBRIDGE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CAMBRIDGE MARYLAND HOSPITAL, INC.</b>			d. STREET ADDRESS <b>CORDTOWN</b>		
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>HENRY</b> Last <b>CHESTER, JR</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>6</b> Year <b>19 67</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 17, 1887</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>DORCHESTER CO., MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>ROBERT H. CHESTER, SR.</b>		
14. MOTHER'S MAIDEN NAME <b>HARRIETT ANNE JACKSON</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>214-07-9531 A</b>			17. INFORMANT <b>FRANCES BROWN</b> Address <b>CORDTOWN, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangrene of left leg</b> <b>455X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May 22</b> , 19 <b>67</b> , to <b>June 6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>June 6</b> , 19 <b>67</b> , and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE <i>[Signature]</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>June 10, 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. EDWIN FASSETT, M.D.</b>		22d. ADDRESS <b>623 HIGH STREET CAMBRIDGE, MD.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CORDTOWN</b>	23d. LOCATION (City or Town) (County) (State) <b>CORDTOWN DORCHESTER MD.</b>		
24. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS <b>CAMBRIDGE, MD.</b>		25a. RECEIVED BY REGISTRAR <b>14 1967</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2002

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08100

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08088

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b>			c. LENGTH OF STAY IN 1b <b>10 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b> 09-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Finchville</b>				d. STREET ADDRESS <b>R.F.D. #1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILBUR JENNINGS CHRISTOPHER</b>				4. DATE OF DEATH Month Day Year <b>June 18, 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1898</b>		9. AGE (In years lost, birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Continental Can Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert J. Christopher</b>				14. MOTHER'S MAIDEN NAME <b>Ida M. Marshall</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-03-5904</b>		17. INFORMANT Address <b>Mrs. Sarah A. Christopher, Federalsburg, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Mace Jr.</b> M.D.				22. DATE SIGNED <b>6/20/67</b>			
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>				Address (Street, city, town, or county) <b>Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 21, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market</b>		23d. LOCATION (City or Town) (County) (State) <b>East New Market-Dorchester-Md</b>	
24. FUNERAL HOME ADDRESS <b>Frampton Funeral Home</b>				25a. BY DECEASED'S REQUEST <b>JUN 23 1967</b>		25b. BY DECEASED'S REQUEST <b>John Mace Jr.</b>	

5. *Conclusions*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08101					CERTIFICATE OF DEATH			08090	
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Queen Anne</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Preston</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Centreville 17-2</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Debra Cole man</b>					4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 67</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-13-1883</b>		9. AGE (In years last birthday) <b>84</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Queen Anne</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ja mes Edward Cheers</b>					14. MOTHER'S MAIDEN NAME <b>Mary Anthony</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) <b>no</b>			16. SOCIAL SECURITY NO. <b>093-26-9944</b>		17. INFORMANT <b>John Anthony</b>			Address <b>RFD Centreville</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Decompensation c auricular fibrillation</b> DUE TO <b>4211</b> (b) <b>Chronic Congestiv4 Heart Failure extolled</b> DUE TO <b>Marked Aortic Insufficiency</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 dys</b> <b>5 Yrs</b> <b>15yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebrovascular Accident (hemorrhage) 10 days</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1/8/57</b> , 19 <b>6/13/67</b> , 19 <b>6/13/67</b> , that (I) (we) last saw the deceased alive on <b>6/12/67</b> 19 <b>6/12/67</b> , and that death occurred at <b>12P</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Harold B. Plummer M.D.</b>					22d. ADDRESS <b>P.O. Box #158 Preston Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-17-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem</b>			23d. LOCATION (City or Town) (County) (State) <b>Centreville Queen Anne Md</b>		
24. FUNERAL DIRECTOR <b>H. H. Dashiell-Easton Jr</b>					25a. REC'D BY REGISTRAR DATE <b>JUN 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08102

08091

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. LENGTH OF STAY in lb <b>2 MO.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MANOKIN</b>		d. STREET ADDRESS <b>Box 84, Route 2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MOLLIE C. FONTAINE</b>		4. DATE OF DEATH Month Day Year <b>JUNE 16 19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1869?</b>
9. AGE (In years last birthday) <b>98 7 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JAMES COTTMAN</b>		14. MOTHER'S MAIDEN NAME <b>FANNIE -</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-16-7104A</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) <b>Senile cachexia</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/25</b> , 19 <b>67</b> , to <b>6/16</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/16</b> 19 <b>67</b> , and that death occurred at <b>105</b> PM, from causes and on the date stated above.			
22a. SIGNATURE <b>Carlos F. Barroso</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>CARLOS F. BARROSO</b>		22b. DATE SIGNED <b>6/16/67</b>	
22d. ADDRESS <b>E.S.S. HOSPITAL, CAMBRIDGE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REV. BUR.</b>		23b. DATE THEREOF <b>6/25/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MANOKIN</b>		23d. LOCATION (City or Town) (County) (State) <b>SOMERSET CO. MD.</b>	
24. FUNERAL DIRECTOR <b>John C. Stain</b>		25a. REC'D BY REGISTRAR <b>JUN 23 1967</b>	
ADDRESS <b>CAMBRIDGE, MA</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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THE NEW YORK STATE DEPARTMENT OF CORRECTIONS

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08103

CERTIFICATE OF DEATH

08092

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>17-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>RFD</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Mary</u> Last <u>Fox</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-73</u>
9. AGE (In years lost birthday) yrs. <u>93</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>F. W. Fox</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Watkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-01954</u>	
17. INFORMANT <u>Mrs LaRue Ordegrove</u>		Address <u>Stevensville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left-Sided Pneumonia; Arteriosclerotic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>4</u> (this hospital) attended the deceased from <u>3-10-</u> , 19 <u>67</u> , to <u>6-9-</u> , 19 <u>67</u> , that <u>4</u> (we) last saw the deceased alive on <u>6-9-</u> , 19 <u>67</u> , and that death occurred at <u>9pm</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward Lewis, Jr.</u>		22b. DATE SIGNED <u>6-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS, JR., MD</u>		22d. ADDRESS <u>Eastern Shore State Hosp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Witzke Funeral Director</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

1010

DATE OF DEATH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08104

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08093

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Dist. Columbia</b> b. COUNTY <b>- - -</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>	c. LENGTH OF STAY IN lb <b>One day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD #3, Cooks Point Road</b>		d. STREET ADDRESS <b>114 Varnum Street, N.E.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JAMES Wooding HINES</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 21, 1907</b>
9. AGE (In years lost birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>59</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dist. Bakery Prod. Division</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Hines</b>	
14. MOTHER'S MAIDEN NAME <b>Grace Dampier</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>None</b>	
16. SOCIAL SECURITY NO. <b>577-01-6921</b>		17. INFORMANT <b>Mrs. J. W. Hines, 114 Varnum St., N. E. Washington, D. C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). storing the underlying cause lost. (b) <b>4201</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		22. DATE SIGNED <b>6/19/67</b> Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 22, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Maryland</b>
24. FUNERAL DIRECTOR <b>John B. Thomas Warner Pumphrey, 8434 Georgia Ave., Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 22 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





08105

## CERTIFICATE OF DEATH

08094

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND X		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Lucomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>306 Elizabeth St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HADLEY FRANCIS Hobbs</u>		4. DATE OF DEATH Month Day Year <u>June 4 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>08-24-1909</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>9 10</u>	IF UNDER 24 HRS. Hours Min. <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shirt Factory</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Lafayette Hobbs</u>		14. MOTHER'S MAIDEN NAME <u>SARA CAREY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-1833</u>	
17. INFORMANT <u>John F. Hobbs (Son)</u>		18. ADDRESS <u>408 Newton Terrace, Salisbury, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Generalized Arteriosclerosis</u> DUE TO <u>Hypertension - aging</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebro-vascular accident</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> , 19 <u>67</u> , to <u>June 4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>June 4</u> , 19 <u>67</u> , and that death occurred at <u>1:40</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Milton O. Kepler</u>		22b. DATE SIGNED <u>6-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MILTON O. KEPLER</u>		22d. ADDRESS <u>East Shore State Hosp Cambridge MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Fruitland, Maryland</u>
24. FUNERAL DIRECTOR <u>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 8 1967</u>	

MADE BY HAND

2000

THESE RECORDS ARE LEGAL EVIDENCE OF THE ACTS OF THE GOVERNMENT

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/10/00 BY 60322 UCBAW/STP

08106

## CERTIFICATE OF DEATH

08095

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>				c. LENGTH OF STAY IN 1b <u>2 months 1 day</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>Sherwood (Rural)</u>			
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Bowers</u> Last <u>Hopkins</u>				4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/11/1884</u>	
9. AGE (In years lost birthday) yrs. <u>82</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND - U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Clarence Hopkins</u>				14. MOTHER'S MAIDEN NAME <u>ANNA WILKENS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>220-44-86575</u>		17. INFORMANT Address <u>Eastern Shore State Hospital (Medical Record)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>Senile cachexia -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome with arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 29<sup>th</sup> 1967</u> , to <u>June 9<sup>th</sup> 1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>June 9<sup>th</sup> 1967</u> , and that death occurred at <u>7<sup>45</sup> A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Carlos F. Barroso</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-9-67.</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u>				22d. ADDRESS <u>Hurlock Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Family Burial Ground</u>		23d. LOCATION (City or Town) (County) (State) <u>Wye Mills, Md.</u>	
24. FUNERAL DIRECTOR <u>Harmon E. Leonard, St. Michaels, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00107

Bochevaler

(George the (small) Smith's (Shorwood (Kean)

Eastern Shore State Hospital

Emily

Bowers Hopkins

Female white

11/11/1944

82

Maryland - USA

John Clarence Hopkins

Anna Wilkins

250-14-1022 Eastern Shore State Hospital (Maryland)

June 17, 61

March 27, 1961

John Clarence Hopkins and Anna Wilkins

John Clarence Hopkins and Anna Wilkins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08107		CERTIFICATE OF DEATH				08096			
1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>O.A.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>			c. LENGTH OF STAY IN 1b <b>4 MO.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CENTREVILLE</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>					d. STREET ADDRESS <b>ROUTE 3</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>JACKSON</b> Last <b>JACKSON</b>					4. DATE OF DEATH Month <b>JUNE 13</b> Day <b>19</b> Year <b>67</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1886 ?</b>		9. AGE (In years last birthday) yrs. <b>81 ?</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>QUEEN ANNE MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>-UNKNOWN</b>					14. MOTHER'S MAIDEN NAME <b>HENNIE GASSAWAY</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vasculer accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>FEB. 27</b> , 19 <b>67</b> , to <b>JUNE 13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>JUNE 13</b> , 19 <b>67</b> , and that death occurred at <b>?</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>E. C. FERNANDEZ</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/13/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>E. C. FERNANDEZ</b>					22d. ADDRESS <b>E.S.S. HOSPITAL, CAMBRIDGE, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>6-16-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EARL CHAPEL</b>		23d. LOCATION (City or Town) (County) (State) <b>MD. CENTREVILLE, MD.</b>			
24. FUNERAL DIRECTOR <b>Charles Judge</b>					25. REC'D BY REGISTRAR <b>JUN 19 1967</b>		26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

0180

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		RELIGION	
MARRIED		SINGLE	
OCCUPATION		EDUCATION	
PLACE OF BIRTH		DATE OF BIRTH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES	
SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	

1-1-1919



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08097

08108		1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND <u>X</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE (RURAL) approx 5 days</u>		c. LENGTH OF STAY IN 1b <u>172</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARYDEL (RURAL)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN Shore State Hospital</u>		d. STREET ADDRESS <u>R.F.D. #1 Box 155</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Douglas</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>00-00-82?</u>	9. AGE (In years last birthday) <u>85?</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not listed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wesley Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Lou Cindy Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>not listed</u>		17. INFORMANT <u>Eastern Shore State Hospital (Medical Record)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Nephrosclerosis</u> DUE TO (b) <u>Diabetes mellitus</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>20 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-21</u> , 19 <u>65</u> , to <u>6-29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-29</u> 19 <u>67</u> , and that death occurred at <u>4</u> AM, from causes and on the date stated above.					
22a. SIGNATURE <u>Carlos F. Barroso</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u>		22d. ADDRESS <u>Hurlock Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HADAWAY CHARLES</u>	
23d. LOCATION (City or Town) <u>Chesapeake Kent Md</u>		23e. (County) <u>Queen Anne</u>		23f. (State) <u>Md</u>	
24. FUNERAL DIRECTOR <u>Fennell Kelly</u>		ADDRESS <u>Chesapeake Kent Md</u>		25a. REC'D BY REGISTRAR <u>JUL 6 1967</u>	
25b. REGISTERED <u>John J. Judge</u>		DATE <u>JUL 6 1967</u>			

7030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
08109 CERTIFICATE OF DEATH 08098

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>10 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Reba</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1893</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Church Creek</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frank E. Vickers</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Howard C. Jones, Church Creek, Md.</b>	
17. INFORMANT <b>Howard C. Jones, Church Creek, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSION</b> DUE TO (c) <b>ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>5 YRS</b> <b>UNDER</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/1</b> , 19 <b>66</b> , to <b>6/9</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>6/9</b> , 19 <b>66</b> , and that death occurred <b>6:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Alfred R. Maryanov</b>		22b. DATE SIGNED <b>6/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALFRED R. MARYANOV</b>		22d. ADDRESS <b>610 RACE ST, CAMBRIDGE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 11, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Old Trinity Churchyard, Church Creek, Md.</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>	
24. FUNERAL DIRECTOR <b>Kenneth R. Howard</b>		25a. RECEIVED BY REGISTRAR <b>14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		DATE	

533

1998

TABLE 5

1  
FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08099

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>15 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>612 Chesapeake Court</b>		d. STREET ADDRESS <b>612 Chesapeake Ct.</b>	
3. NAME OF DECEASED (Type or print) <b>Willie Lawrence</b>		4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1920</b>
9. AGE (In years last birthday) <b>46 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Susie Douglas, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4341 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		22. DATE SIGNED <b>6/8/67</b> Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/11/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Dor., Md.</b>	
24. FUNERAL DIRECTOR <b>St. Clair Funeral Co. Cambridge, Md.</b>		25a. REC'D BY REGISTRAR <b>14 1967</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

15000

15000

Handwritten notes and signatures, including the name "John" and "John" at the bottom.



08111

## CERTIFICATE OF DEATH

08100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Cambridge</b>			c. LENGTH OF STAY IN Tb <b>50 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Cambridge</b> <b>09-1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>				d. STREET ADDRESS <b>RFD 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mamie Elizabeth Lee</b>				4. DATE OF DEATH Month Day Year <b>June 13, 1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 27, 1897</b>	
9. AGE (In years lost birthday) <b>76 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Talbot County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Moaney</b>				14. MOTHER'S MAIDEN NAME <b>Julia Bolden</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-32-2947A</b>		17. INFORMANT Address <b>Hester Stanley, RFD 2, Cambridge, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arteriosclerotic heart disease</b> DUE TO (b) <b>4200</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 6, 1967</b> , to <b>June 13, 1967</b> , that (I) (we) lost saw the deceased alive on <b>June 13, 1967</b> and that death occurred at <b>June 13, 1967</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED <b>June 15, 1967</b>		22c. PHYSICIAN'S NAME (Type) J. <b>EDWIN FASSETT, MD</b>	
22d. ADDRESS <b>623 HIGH STREET CAMBRIDGE, MD.</b>				22e. REC'D BY REGISTRAR <b>JUN 16 1967</b>		22f. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/18/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cordtown Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Dorchester County, Md.</b>	
24. FUNERAL DIRECTOR <i>[Signature]</i>				25. ADDRESS <b>Cambridge, Md.</b>			

00150

STANDARD FORM NO. 64

70180

1. NAME OF THE ORGANIZATION OR INDIVIDUAL		2. TITLE OF THE PROJECT OR PROGRAM	
3. NAME OF THE PERSONNEL		4. POSITION OF THE PERSONNEL	
5. ADDRESS OF THE PERSONNEL		6. CITY AND STATE	
7. PHONE NUMBER		8. FAX NUMBER	
9. E-MAIL ADDRESS		10. OTHER CONTACT INFORMATION	
11. DATE OF THE PROJECT		12. DURATION OF THE PROJECT	
13. BUDGET OF THE PROJECT		14. SOURCE OF FUNDS	
15. DESCRIPTION OF THE PROJECT		16. OBJECTIVES OF THE PROJECT	
17. METHODS OF THE PROJECT		18. RESULTS OF THE PROJECT	
19. CONCLUSIONS OF THE PROJECT		20. RECOMMENDATIONS OF THE PROJECT	

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08112

08101

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>about 60 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>120 Mill Street</b>				d. STREET ADDRESS <b>120 Mill Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT H. MATTHEWS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 27, 1884</b>		9. AGE (In years lost birthday) <b>82</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Realtor-Ins. Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate- Ins.</b>		11. BIRTHPLACE (State or foreign country) <b>Fairmount, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Sewell Matthews</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Esther Dobson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT Address <b>Donald E. Matthews, Cambridge, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6/20/67</b> Address (Street, city, town, or county) <b>Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 21, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 7 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. [unclear]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

09529

08113

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CAMBRIDGE MARYLAND HOSPITAL, INC.</b>		e. STREET ADDRESS <b>AIREYS, MD.</b>	
3. NAME OF DECEASED (Type or print) First <b>SOPHIE</b> Middle <b>T.</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 8, 1874</b>
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months <b>29</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>DORCHESTER CO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES H. THOMAS</b>		14. MOTHER'S MAIDEN NAME <b>MARY NASH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-56-1786</b>	
17. INFORMANT <b>BELLE BURROUGHS</b>		Address <b>AIREYS, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> DUE TO (b) <b>arteriosclerotic C.V.D.</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 29, 1967</b> , to <b>June 29, 1967</b> (that I) (we) last saw the deceased alive on <b>June 29, 1967</b> , and that death occurred at <b>June 29, 1967</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>J. EDWIN FASSETT, M.D.</b>		22b. DATE SIGNED <b>June 30, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. EDWIN FASSETT, M.D.</b>		22d. ADDRESS <b>623 HIGH STREET CAMBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/2/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SALEM</b>		23d. LOCATION (City or Town) (County) (State) <b>SALEM DORCHESTER MD.</b>	
24. FUNERAL DIRECTOR <b>Fredrick C. Delius</b>		25a. REC'D BY REGISTRAR <b>JUL 11 1967</b>	
ADDRESS <b>CAMBRIDGE, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

ESTIMATE BY DEATH

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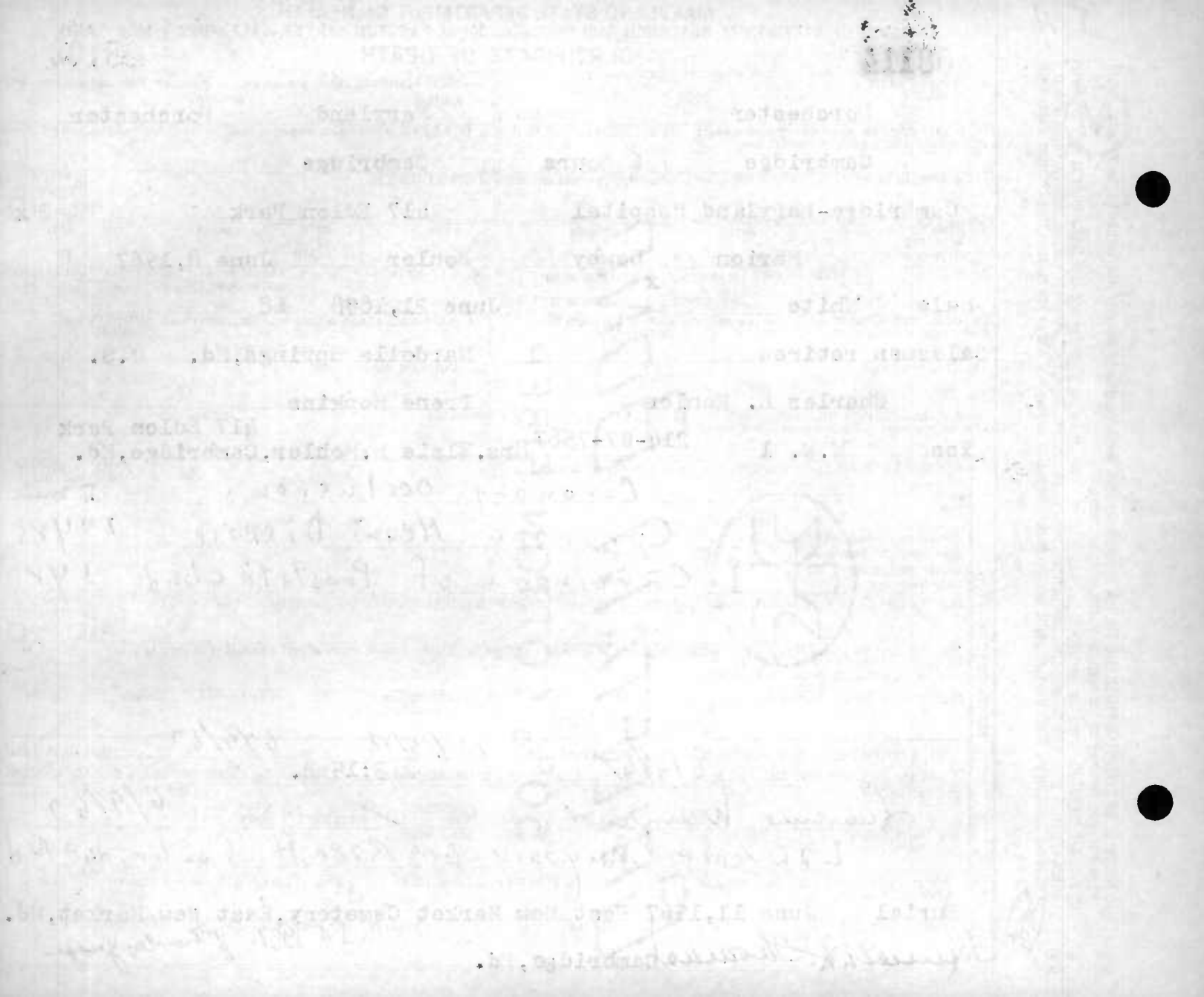


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
08114 CERTIFICATE OF DEATH 08102

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>6 Hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
f. STREET ADDRESS <b>417 Edlon Park</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marion</b> Middle <b>Dewey</b> Last <b>Mohler</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1898</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Mardella Springs, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles L. Mohler</b>		14. MOTHER'S MAIDEN NAME <b>Irene Hopkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 1 214-07-7587</b>	
17. INFORMANT <b>Mrs. Elsie H. Mohler, Cambridge, Md.</b>		Address <b>417 Edlon Park</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary Occlusion</b> DUE TO (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>Carcinoma of Prostate gland</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>20 yrs</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/13/45</b> to <b>6/9/67</b> , that (I) (we) last saw the deceased alive on <b>6/9/67</b> , and that death occurred at <b>3:15 PM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Lawrence Maryanov</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED <b>6/9/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b>	
22d. ADDRESS <b>60 Race St. Cambridge, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>June 11, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery, East New Market, Md.</b>	
23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR <b>James H. Thomas</b> ADDRESS <b>Cambridge, Md.</b>	
25a. RECD BY REGISTRAR <b>June 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08115

CERTIFICATE OF DEATH

08103

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Der</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>1 wk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u> <u>09.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Clyde</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/12/1904</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill worker - Adkins, Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Moore</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Lanford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs John Clyde Moore, Hurlock, Md</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic pyelonephritis</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>6000</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia, Congestive heart failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> , 19 <u>67</u> , to <u>June 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 18</u> , 19 <u>67</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Carlos F. Barroso</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u>	
22d. ADDRESS <u>Hurlock Md</u>				22e. ADDRESS		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>6/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		23d. LOCATION (City, town or county) (State) <u>Hurlock Md</u>	
24. FUNERAL DIRECTOR <u>Kath S. Willoughby, East New Market, Md</u>		25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			

10000

10000

Handwritten notes and signatures, including names like "John W. Adams" and "Edward Adams", and dates like "1851".

88116

## CERTIFICATE OF DEATH

08104

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Williamsburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Williamsburg</u>	
c. LENGTH OF STAY IN lb <u>Two Years</u>		d. STREET ADDRESS <u>St. Marys Rest Home</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Marys Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie</u>		4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1895</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Trehern</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-114-4084</u>	
17. INFORMANT <u>Nellie Jones, Baltimore, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (d).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction near the Colostomy</u> <u>1538</u> DUE TO Colostomy from Carcinoma of the Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Colostomy from Carcinoma of the Colon</u> (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Heart Disease Mentally Incompetent</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/30/66</u> , 19 <u>66</u> to <u>6/7/67</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>6/7</u> , 19 <u>67</u> , and that death occurred on <u>6:30 A</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Harold B. Plummer</u>		22b. DATE SIGNED <u>6/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold B. Plummer M.D.</u>		22d. ADDRESS <u>P.O. Box #158 Preston Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/14/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cambridge, Maryland</u>
24. FUNERAL DIRECTOR <u>Herbert M. A. Claiborne</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 16 1967</u>	
ADDRESS <u>Cambridge, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1982



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>30 Years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>205 Crusader Road</b>					d. STREET ADDRESS <b>205 Crusader Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Byrn</b> Last <b>Phelps</b>			4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1967</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 8, 1892</b>		9. AGE (In years last birthday) <b>75</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance salesman, Ret.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Cambridge, Md., R.D. 2</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Francis P. Phelps</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Byrn</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>W.W. 1</b>		17. INFORMANT <b>Mrs. Eva L. Phelps, Cambridge, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis acute</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis (V.D.)</b> DUE TO (c) <b>Arteriosclerosis gen</b>								INTERVAL BETWEEN ONSET AND DEATH <b>594</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1946</b> to <b>6/20</b> , 1967, that (I) (we) last saw the deceased alive on <b>6/20</b> 1967, and that death occurred at <b>12:15</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>James G. Thompson</b>					22b. DATE SIGNED <b>6/20/67</b>			22c. PHYSICIAN'S NAME (Type) <b>James G. Thompson</b>	
22d. ADDRESS <b>Cambridge, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>June 22, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park, Cambridge, Md.</b>		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <b>Kenneth R. Thomas</b>					25a. REC'D BY REGISTRAR <b>JUN 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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## CERTIFICATE OF DEATH

08106

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WICOMICO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>				c. LENGTH OF STAY IN 1b <b>29 YEARS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>				d. STREET ADDRESS <b>Pine Street</b>			
3. NAME OF DECEASED (Type or print) First <b>ROGER</b> Middle <b>Williams</b> Last <b>PUSEY</b>				4. DATE OF DEATH Month <b>JUNE 16</b> Day <b>19</b> Year <b>67</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/10/05</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturing Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MD. Wicomico Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>REVERDY PUSEY</b>				14. MOTHER'S NAME <b>DORA WILLIAMS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>W. Gilbert Pusey (Brother)</b> Address <b>118 Lakeview Dr. Salisbury, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>H341</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>9 DAYS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>3/17</b> , 19 <b>38</b> , to <b>6/16</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/16</b> , 19 <b>67</b> , and that death occurred at <b>5:30</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>E. Fernandez</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/16/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>EFRAIN C. FERNANDEZ</b>		22d. ADDRESS <b>E.S.S. HOSPITAL, CAMBRIDGE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 18, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephens Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Delmar, Delaware</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>JUN 20 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08107

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Queen Anne's Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN Shore State Hospital</b>		d. STREET ADDRESS <b>715 Glendale Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Rufus</b> Middle <b>Edmund</b> Last <b>Radcliffe</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>CAUCASION</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 21, 1884</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poultry</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Stevensville Q.A.Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Alfred Radcliffe</b>		14. MOTHER'S MAIDEN NAME <b>Annie Elms</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-01-3735</b>	
17. INFORMANT <b>WIFE</b> Address <b>Mrs. Ebbal L. Radcliffe, Centreville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED ARTERIOSCLEROSIS</b> 4531 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>AND Buerger's Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>? 2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Poss. Pulmonary Abscess; Urinary Bleeding</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>if</del> (this hospital) attended the deceased from <b>6-21-</b> , 19 <b>67</b> to <b>6-24-</b> , 19 <b>67</b> , that <del>if</del> (we) last saw the deceased alive on <b>6-24-</b> , 19 <b>67</b> , and that death occurred at <b>9:00</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Edward Lewis Jr. M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>6-24-67</b>
22c. PHYSICIAN'S NAME (Type) <b>EDWARD LEWIS JR. MD</b>		22d. ADDRESS <b>EASTERN SHORE STATE HOSP.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>JUNE 22, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Centreville, Q.A.Co. Md.</b>
24. FUNERAL DIRECTOR <b>James H. Baiter, Barton Bros. Centreville, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 27 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Johnas Judge</b>





**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

08120

## CERTIFICATE OF DEATH

08108

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. LENGTH OF STAY IN b. <u>approximately 18 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>Westover (Rural)</u>	
3. NAME OF DECEASED (Type or print) First <u>ONA</u> Middle <u>MAY</u> Last <u>Reid</u>		4. DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01-09-87</u>
9. AGE (In years last birthday) yrs. <u>80</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Taylor</u>		14. MOTHER'S MAIDEN NAME <u>MARY Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>Med. Care #3248</u>	
17. INFORMANT <u>Eastern Shore State Hospital (Medical Records)</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic brain generalized debilitation</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>chronic brain syndrome</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <u>5-20-1966</u> , to <u>6-28-1967</u> , that (H) (we) last saw the deceased alive on <u>6-28-1967</u> , and that death occurred at <u>12:45</u> A.M., from causes and on the date stated above			
22a. SIGNATURE <u>John Blair Webster</u>		22b. DATE SIGNED <u>6-28-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beechwood</u>	23d. LOCATION (City or Town) (County) <u>Princess Anne Somerset Md (State)</u>
24. FUNERAL DIRECTOR <u>James H. Hannon - Princess Anne</u>		25a. REC'D BY REGISTRAR <u>JUN 30 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	

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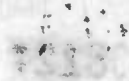
## CERTIFICATE OF DEATH

09535

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN lb <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CAMBRIDGE MARYIA ND HOSPITAL, INC.</b>		d. STREET ADDRESS <b>818 ROBBINS STREET</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES EDWARD ROBINSON</b>		4. DATE OF DEATH <b>JUNE 21, 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 11, 1893</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>DORCHESTER CO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN ROBINSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELIZABETH CLASH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-09-1898 A</b>	
17. INFORMANT <b>MARY AGNES ROBINSON</b>		Address <b>CAMBRIDGE, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> DUE TO <b>Hypertensive Arteriosclerotic C.V.D.</b> DUE TO (c) <b>-----</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 24, 1967</b> , to <b>June 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 21, 1967</b> , and that death occurred at <b>-----</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. J. Edwin Fassett</b>		22b. DATE SIGNED <b>June 22, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. J. Edwin Fassett, M.D.</b>		22d. ADDRESS <b>P.O. 576 623 High Street</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6/24/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BETHEL</b>	23d. LOCATION (City or Town) (County) (State) <b>CAMBRIDGE DOR. MD.</b>
24. FUNERAL DIRECTOR <b>Julius C. Deane</b>		25a. REC'D BY REGISTRAR <b>JUL 11 1967</b>	
ADDRESS <b>CAMBRIDGE, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08122

CERTIFICATE OF DEATH

08109

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b <b>entire life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>900 Maryland Ave.,</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>900 Maryland Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mitchell</b> Middle <b>Shorter</b> Last <b>Shorter</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1897</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. UNDER 1 YEAR Months <b>6</b> Days <b>9</b> Hours <b>1</b> Min.	11. UNDER 24 HRS. Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>State Hospital Attendant, Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Sewards, Dorchester Co., U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jesse Shorter</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Willey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>400 Maryland Ave</b>	
17. INFORMANT <b>Mrs. Ida May Shorter, Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric haemorrhage</b> 592X DUE TO (b) <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>nephritis, chronic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>acute</b> ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia, old hemiplegia etc</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 29</b> , 19 <b>67</b> , to <b>June 30</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>June 29</b> , 19 <b>67</b> and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>7/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		22d. ADDRESS <b>[Signature]</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 2, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>	
24. FUNERAL DIRECTOR <b>Leuneth R. Thomas</b>		25a. REC'D BY REGISTRAR <b>JUL 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

001336

DEPARTMENT OF DEATH

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CERTIFICATE OF DEATH

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88123

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rhodesdale - Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>		d. STREET ADDRESS <b>R.F.D.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>DELLA</b> Last <b>SINGLETARY</b>		4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19, 1903</b>
9. AGE (In years lost birthday) yrs. <b>64</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Stanley</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-16-9357</b>	
17. INFORMANT <b>Ida Singletary, Rhodesdale, Md., RFD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pulmonary embolism</b> 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>embolism</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>B. W. Rieckert</b>		22b. DATE SIGNED <b>6-5-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. W. Rieckert</b>		22d. ADDRESS <b>East New Market</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 10, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rhodesdale Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Near Rhodesdale, Maryland</b>
24. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUN 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4011-3

1000

STATE OF TEXAS

County of \_\_\_\_\_

County of \_\_\_\_\_

Section \_\_\_\_\_

Block \_\_\_\_\_

Tract \_\_\_\_\_

Survey \_\_\_\_\_

Survey \_\_\_\_\_

Containing \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
081224 CERTIFICATE OF DEATH 08111									
1. PLACE OF DEATH a. CDUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>4 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Madison</b> d. STREET ADDRESS <b>Route 16 Rural</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Snook</b> Last <b>Snook</b>					4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1967</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 1, 1886</b>		9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Rutherford, Ontario</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Lyman W. Snook</b>					14. MOTHER'S MAIDEN NAME <b>Sarah E. Oliver</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-48-2444</b>		17. INFORMANT <b>Frederick S. Snook, Madison, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>DIABETES MELLITUS</b>									INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <b>5-17</b> , 19 <b>62</b> , to <b>6-14</b> , 19 <b>62</b> , that (2) (we) last saw the deceased alive on <b>6-14</b> , 19 <b>62</b> , and that death occurred <b>2 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>James F. McCarter</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6-14-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>JAMES F. MCCARTER</b>					22d. ADDRESS <b>Box 386 Cambridge, Maryland 21613</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>June 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Joppa Churchyard</b>		23d. LOCATION (City, town or county) (State) <b>Madison, Md.</b>		
24. FUNERAL DIRECTOR <b>Herbert L. Thomas Jr.</b>					25a. REC'D BY REGISTRAR <b>JUN 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08125

CERTIFICATE OF DEATH

08112

1. PLACE OF DEATH a. COUNTY <u>DERCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENNEDYVILLE</u> 14.2	
c. LENGTH OF STAY IN 1b <u>2mo. 13 days</u>		d. STREET ADDRESS <u>none</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Daisie ATKINS STROLE</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1967</u> 19	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-80</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia - USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE ATKINS</u>		14. MOTHER'S MAIDEN NAME <u>Slusher ELIZABETH ATKINS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>219 56 8075</u>	
17. INFORMANT <u>EASTERN SHORE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Myocardial Infarction</u> DUE TO <u>Coronary artery occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>0 -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>03-22, 1967</u> to <u>06-04, 1967</u> , that (I) (we) last saw the deceased alive on <u>06-04, 1967</u> , and that death occurred at <u>9:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Milton O. Kepler</u>		22b. DATE SIGNED <u>6-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MILTON O. KEPLER</u>		22d. ADDRESS <u>Eastern Shore State Hosp Cambridge MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shrewsbury Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>near Kennedyville, Md.</u>
24. FUNERAL DIRECTOR <u>J. Willis Wells</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
ADDRESS <u>Chestertown, Md.</u>		DATE <u>JUN 6 1967</u>	

ESTIMATE OF VALUE

53130

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be a detailed description of land parcels, possibly including acreage, location, and ownership details.]*



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08126

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08113

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishops Head</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishops Head</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>				d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PERCY</b> Middle <b>TODD</b> Last				4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>June 3, 1884</b>		9. AGE (In years lost birthday) <b>83</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Noah L. Todd</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Insley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-1670</b>		17. INFORMANT Address <b>Mrs. Leonard Bramble, Bishops Head, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Mace Jr.</b>		EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>6/8/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 10, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08127

CERTIFICATE OF DEATH

08114

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN lb <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		d. STREET ADDRESS <b>303 Maryland Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>303 Maryland Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>BRAMBLE</b> Last <b>TRAVERS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1896</b>
9. AGE (In years last birthday) yrs. <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>T. Milbourne Bramble</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Mills</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>Mr. Herbert Travers, Cambridge, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Pancreas</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-23-62</b> , 19__, to <b>6-16-67</b> , 19__, that (I) (we) last saw the deceased alive on <b>6-11-67</b> , 19__, and that death occurred at <b>4 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Albert E. Bunker</i>		22b. DATE SIGNED <b>6-19-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Albert E. Bunker, M. D.</b>		22d. ADDRESS <b>200 Md. Ave., Cambridge, Md. 21613</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 18, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25. DIRECTED BY REGISTRAR DATE <b>26 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08128 CERTIFICATE OF DEATH 08115									
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>5 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>					d. STREET ADDRESS <b>716 Race Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Randolph</b> Last <b>Trigger</b>					4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 3, 1922</b>		9. AGE (In years last birthday) <b>45 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Fredericksburg, Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James H. Trigger</b>					14. MOTHER'S MAIDEN NAME <b>Amanda Shackelford</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>252-09-4273</b>		17. INFORMANT <b>Mrs. Amanda North, Cambridge, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LAENNEC'S CIRRHOSIS</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from <b>5-24-67</b> 19 to <b>6-1-67</b> 19, that (we) last saw the deceased alive on <b>6-1-67</b> 19, and that death occurred at <b>4:34</b> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>James F. McCarter</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>6-2-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES F. McCARTER, M.D.</b>					22d. ADDRESS <b>Box 386 Cambridge, Md. 21613</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 3, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>		
24. FUNERAL DIRECTOR <b>Samuel D. Thomas</b>					ADDRESS <b>Cambridge, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>

PLATE 20



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08129

CERTIFICATE OF DEATH

08116

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Zucen Anne</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN lb <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CEUMPTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>			d. STREET ADDRESS <u>Box 112</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Hackett</u> Last <u>Vansant</u>			4. DATE OF DEATH Month <u>06</u> Day <u>04</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>01-06-74</u>		9. AGE (In years lost birthday) yrs. <u>93</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Kent Co. Maryland</u>	
13. FATHER'S NAME <u>John N. Vansant</u>			14. MOTHER'S MAIDEN NAME <u>Emily C. Cooke</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>215-14-5395</u>		17. INFORMANT Address <u>Eastern Shore State Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>11200</u> (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>aging - senescence</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia and Cachexia</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>05-24</u> , 1967, to <u>06-04</u> , 1967, that (I) (we) last saw the deceased alive on <u>06-04</u> 1967, and that death occurred at <u>8:15</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Milton O. Kepler</u>			22b. DATE SIGNED <u>6-4-67</u>		22c. PHYSICIAN'S NAME (Type) <u>MILTON O. KEPLER</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>June 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Galena Cemetery</u>
24. FUNERAL DIRECTOR <u>Edward Fellows</u>			25a. REC'D BY REGISTRAR <u>June 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

2250

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08130

08117

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>				c. LENGTH OF STAY IN 1b <i>5 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>rural Trappe</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Glasgow Nursing Home</i>				d. STREET ADDRESS <i>20-2</i>			
3. NAME OF DECEASED (Type or print) <i>DAISY V. WATTS</i>				4. DATE OF DEATH Month <i>June</i> Day <i>24</i> Year <i>1967</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 2, 1883</i>	9. AGE (In years lost birthday) <i>83</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Dorchester, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>
13. FATHER'S NAME <i>William Sand</i>				14. MOTHER'S MAIDEN NAME <i>Emma Frazier</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>213-16-7399</i>		17. INFORMANT <i>Mrs. James S. Chaplain</i> Address <i>13 Willis St. Easton, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X Cerebrovascular Accident</i> DUE TO (b) <i>generalized Arteriosclerosis</i> DUE TO (c) <i>10 yrs</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <i>o.m.</i> <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6/23/67</i> to <i>6/24/67</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6/24/67</i> , and that death occurred at <i>6:15</i> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Lawrence Maryanov</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>6/27/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Dr. Lawrence Maryanov</i>				22d. ADDRESS <i>Cambridge, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-27-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Landing Neck</i>		23d. LOCATION (City or Town) (County) (State) <i>rural Trappe, Talbot, Md.</i>	
24. FUNERAL DIRECTOR <i>Maurice E. Newman, Jr.</i>				ADDRESS <i>Easton, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 29 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

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FOR STATE HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09546

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>?</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hurlock</b>		c. LENGTH OF STAY in 1b <b>2 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>?</b>		483	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spencer Jones Labor Camp</b>		d. STREET ADDRESS <b>?</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Whitney</b> Last <b>Whitney</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) yrs. <b>36</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer, migrant</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Deputy Sheriff Hurley. Cambridge</b>		Address <b>Dor. Cp. Jail</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Shot gun wound chest</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <b>XX</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by Sarah Abney</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12 N.</b> p.m. <b>6/27/67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Labor Camp Near Hurlock, Dor., Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> M.D.		22. DATE SIGNED <b>6/28/67</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>6/28/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. CEMET. U.C.F. Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Harold M. Anderson</b>		25a. REC'D BY REGISTRAR <b>JUL 13 1967</b>	
ADDRESS <b>Cambridge, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08132

CERTIFICATE OF DEATH

08118

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>705 Church St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Hicks</u> Last <u>Willis</u>		4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/30/1900</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. UNDER 1 YEAR Months <u>6</u> Days <u>2</u> Hours <u>19</u> Min.	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hampton B. Hicks</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Paul Willis, Wilmington, Dela</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis bifurcation of abdominal aorta</u> DUE TO (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/31/67</u> to <u>6/2/67</u> , that (I) (we) last saw the deceased alive on <u>6/2</u> 19 <u>67</u> , and that death occurred at <u>3:20</u> M, from the causes and on the date stated above.		22. DATE SIGNED <u>6/3/67</u>	
22a. SIGNATURE <u>Laurence Maryanov</u>		22b. DATE SIGNED <u>6/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Laurence Maryanov</u>		22d. ADDRESS <u>610 Race St. Cambridge, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/5/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d. LOCATION (City, town or county) (State) <u>East New Market, Md</u>	
24. FUNERAL DIRECTOR <u>Luther S. Halloway, East New Market</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 6 1967</u>	

185130

Concord West District  
Thompson's  
3 days

Lawrence H. Campbell, M.D.  
6/13/13  
Lawrence H. Campbell, M.D.  
6/13/13  
6/13/13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08133

CERTIFICATE OF DEATH

08119

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vienna</b>	
c. LENGTH OF STAY IN lb <b>1 week</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		d. STREET ADDRESS <b>unk</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HELEN S. WINSLOW</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>June 27, 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1893</b>
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Hearn</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Peters</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>Mr. David Winslow, Vienna, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA FROM</b> <b>1532</b> DUE TO (b) <b>CARCINOMA OF DESCENDING COLON</b> DUE TO (c) <b>8 mos</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. 'p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 25, 1966</b> , to <b>JUNE 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>JUNE 26, 1967</b> , and that death occurred at <b>7:30 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Alfred R. Maryanov</b>		22b. DATE SIGNED <b>6/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Alfred R. Maryanov, M.D.</b>		22d. ADDRESS <b>610 Race St., Cambridge, Md. 21613</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 29, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 3 1967</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE (RURAL)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		d. STREET ADDRESS <b>416 GOLDSBORO STREET</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LEONARD FAIRBANKS WYATT</b>		4. DATE OF DEATH Month Day Year <b>JUNE 18 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01-06-12</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOSPITAL ATTENDANT</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES WYATT</b>		14. MOTHER'S MAIDEN NAME <b>ALICE KEMP</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>213-05-6233</b>	
17. INFORMANT <b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pending autopsy report</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Coronary occlusion</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>6/19/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/22/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>
24. FUNERAL DIRECTOR <b>MAURICE E. NEUNAM &amp; SON, Easton, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 26 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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